



CANNON BUILDING
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STATE OF DELAWARE
BOARD OF MEDICAL LICENSURE AND DISCIPLINE
MIDWIFERY ADVISORY COUNCIL

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EMAIL: customerservice.dpr@state.de.us

MIDWIFE DISCLOSURE FORM

To be completed by all clients seeking midwifery care

I, the undersigned, acknowledge by placing my signature beside each item that I have been informed of all of the following:

	Sign Below
Midwife Name: _____ Midwife Address: _____ Midwife Telephone No.: _____	
Midwife License No.: _____	
Midwife's education, training, and experience in midwifery in relation to both mother and newborn: _____ _____ _____	
I understand that if any of the following conditions arise during my pregnancy, I will not qualify for a home birth: <ul style="list-style-type: none"> • onset of labor before the 37th week of gestation • lie other than vertex at term • multiple gestations • significant vaginal bleeding, especially of undetermined origin • significant gestational hypertension • gestational diabetes mellitus, uncontrolled by diet • hemoglobin less than 10 mg/dl, not responsive to treatment • evidence of pre-eclampsia • consistent size/date discrepancy • deep vein thrombosis or other significant hematologic syndrome • known fetal anomalies or conditions that would render a home birth unsafe • threatened or spontaneous abortion in the second trimester or later • abnormal ultrasound findings requiring a higher level of care • red cell isoimmunization with rising titer • documented placental anomaly or late term previa • rare diseases or disorders outside of the midwife's scope of care • postdates pregnancy • HIV infection • primary or uncontrolled infection • significant decreased fetal responsiveness or evidence on non-reassuring fetal status. 	

	Sign Below
<p>I understand that if any of the following conditions arise during intrapartum or postpartum care, the midwife must immediately engage emergency medical services, and may continue to assist in the emergency:</p> <ul style="list-style-type: none"> • persistent abnormal bleeding • signs or symptoms of maternal or fetal infection • transverse lie • visualization of active genital herpetic lesion • development of pre-eclampsia or gestational hypertension • abnormal findings on rupture of membranes • seizure • significant hemorrhage, not responsive to treatment • adherent or retained placenta • sustained maternal vital sign instability • suspected uterine prolapse • repair of laceration or episiotomy beyond the midwife's level of expertise • anaphylaxis • cardiopulmonary resuscitation of the mother or newborn with a bag and mask • manual exploration of the uterus for placenta to control severe bleeding. 	
<p>By my signature I acknowledge that I have received a copy of the Emergency Care Form, detailing the plan for the appropriate delivery of emergency care, if necessary, including consultation with other health care providers, emergency transfer, and access to neonatal intensive care units and obstetrical units or other patient care areas.</p>	
<p>By my signature I acknowledge that in the event of an emergency or voluntary transfer, no liability from the actions of the midwife is assignable to the receiving facility or medical professional.</p>	
<p>I understand that I may file a complaint against my midwife's license with the Midwifery Advisory Council by contacting the Delaware Division of Professional Regulation online at: http://www.dpr.delaware.gov/forms/complaints.shtml or by calling (302) 744-4500 and asking to speak to an investigator.</p>	
<p>I understand that my records and any transactions with my midwife are confidential pursuant to the federal Health Insurance Portability and Accountability Act.</p>	
<p>I understand that my midwife:</p> <p><input type="checkbox"/> carries malpractice or liability insurance, or</p> <p><input type="checkbox"/> does not carry malpractice or liability insurance.</p>	

Client Signature: _____ **Date:** _____

Midwife Signature: _____ **Date:** _____